

*St. Joseph Health, Santa Rosa Memorial Hospital
FY18 Community Benefit Report*



St. Joseph Health, Santa Rosa Memorial Hospital

*FY18 Community Benefit Report
Progress on FY18-FY20 CB Plan/Implementation Strategies Report*



To provide feedback about this *Community Benefit Report*, email:
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EXECUTIVE SUMMARY

St. Joseph Health, Santa Rosa Memorial Hospital (SRMH), founded by the Sisters of St. Joseph of Orange, has been serving the healthcare needs of families in the community for more than 60 years. During this time, its mission has remained the same: to continually improve the health and quality of life of people in the communities served. Part of a larger healthcare system known as Providence St. Joseph Health (PSJH), SRMH is part of a countywide ministry that includes two hospitals, urgent care facilities, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region. The ministry's core facilities are Petaluma Valley Hospital (PVH), an 80-bed acute care hospital, and SRMH, a full service, state of the art 338-bed acute care hospital that includes a Level II trauma center for the coastal region from San Francisco to the Oregon border. Major programs and services include critical care, cardiovascular care, stroke care, women's and children's services, cancer care, and orthopedics. SRMH is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

SRMH provides southern Mendocino, northern Marin, and Sonoma counties' communities with access to advanced care and advanced caring. The hospital's service area extends from Ukiah in the north, Marshall in the south, Sonoma Valley in the east and Bodega Bay in the west. SRMH's Total Service Area (TSA) includes a population of 537,000 and the cities of Santa Rosa, Petaluma, Sebastopol, Windsor, Healdsburg, Rohnert Park, Cotati, Sonoma, Cloverdale, Ukiah, and Point Arena. More than 90% of the population of the TSA is in Sonoma County. Compared to the state, Sonoma and Mendocino Counties have higher percentages of elderly and non-Latino Whites. Median income of the TSA is very similar to California but there is less reported poverty. Mendocino County has higher rates of households and children in poverty than both Sonoma and California.

SRMH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved. Each year, SRMH allocates 10 percent of its net income to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospital Care for the Poor programs. In addition, SRMH spends portions of its annual operating budget to operate ongoing community benefit programs targeted at both the economically poor and underserved as well as the broader community. These programs include a free Mobile Health Clinic, Mobile Dental Clinic, fixed-site Dental Clinic, a House Calls program providing in-home care to chronically ill patients, a *Promotores de Salud* program offering Spanish-language health and nutrition education and health screenings, and school-based programs providing health and nutrition education and peer support groups.

Community Benefit Investment

St. Joseph Health, Santa Rosa Memorial Hospital invested \$48,718,594 in community benefit in Fiscal Year 2018, ending June 30, 2018 (FY18). In FY18, Medicaid shortfall was \$26,617,577, however, when hospital fee was accounted for it was \$34,914,247.

FY18-FY20 CB Plan Priorities/Implementation Strategies

In FY18 St. Joseph Health Sonoma implemented the following strategies addressing priorities as developed in its FY18-FY20 Community Benefit Implementation Plan.

A. Access to Resources

- 1) Establish new CARE Network Program:
 - Comprehensive team approach to provide medical care, care coordination, social work supports, and resources navigation to the most vulnerable patient population
 - Integrated behavioral health services would assist all teams
 - Adapt and integrate existing Community Benefit House Calls and Mobile Health Clinic programs with Pop Health's Care Coordination program
 - Pilot a Medical Legal Partnership (MLP) project with Legal Aid of Sonoma County
- 2) Provide preventive healthcare and education programs
 - Continue existing Dental Programs as delivered to children 0-16
 - Continue existing Mobile Health Clinic provision of primary care in the community
 - Continue community health screenings in conjunction with Mobile Health Clinic and other community partners
 - Continue Growing Together Perinatal Program providing resources for pregnant and parenting families

B. Behavioral Health

- 1) Expand psychiatric services and clinical support to address behavioral health needs of vulnerable populations.
 - Form a psychiatric team to manage inpatients and outpatients with complex conditions in support of hospitalists and primary care providers
 - Expand capacity of the SJH Outpatient Behavioral Health Program to serve more low-income patients
 - Provide nurse practitioner at Crisis Stabilization Unit to conduct medical clearances on patients
 - Provide emergency department and inpatient psychiatric liaisons to support patients with behavioral health needs

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- Increase the number of available inpatient psychiatric beds by partnering with County government agencies and other community partners to create a regional Psychiatric Health Facility (PHF).
- 2) Improve access to behavioral health services for high acuity individuals by improving the countywide system of care
 - Convene and backbone a Behavioral Health Working Group of the Committee for Healthcare Improvement (CHI) of Health Action to identify, develop, and implement policies and practices to improve the countywide behavioral health system of care
 - 3) Provide staff leadership and financial support to Petaluma Sober Circle and Sober Sonoma serial inebriate programs.
 - 4) Provide staff leadership and support to align, partner with, and expand upon existing community youth-focused and school-based programs and initiatives addressing behavioral health issues through prevention-focused trauma-informed curricula and approaches.
 - 5) With 3-year funding from St. Joseph Health Community Partnership Fund's Intersections Initiative, form a cross-sectoral *Sonoma Intersections Coalition* to promote policy, systems, and environmental changes addressing housing equity that will lead to improved conditions for community mental health and wellbeing.

C. Homelessness/Housing Concerns

- 1) Expand access for homeless individuals to medical and other support services that improve quality of life and reduce ED use and hospitalizations.
 - Support the provision of needed respite care for homeless patients after discharge from the hospital (*e.g., Project Nightingale*)
 - Support the Homeless Care Transitions program of Santa Rosa Community Health
 - Provide Mobile Medical Team services at shelters and supportive housing locations
 - Convene and support the Health Care for the Homeless Collaborative (HCHC) to coordinate existing and develop new homeless health care services
- 2) Research and bring forward models for expanding Permanent Supportive Housing (PSH) throughout the county and region, with Providence St. Joseph Health system and other community partners
- 3) Play a leadership role on the Continuum of Care Board in re-designing community's system of care for homeless individuals and families

- 4) Align housing equity efforts of the *Sonoma Intersections Coalition* (above) with existing local housing initiatives and providers/developers
- 5) Participate in, partner with, and support existing and new homeless and affordable housing projects and initiatives

PROVIDENCE ST. JOSEPH HEALTH

Providence St. Joseph Health (PSJH) is a new organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Together, our 111,000 caregivers (all employees) serve in 50 hospitals, 829 clinics and a comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. The PSJH family includes: Providence Health & Services, St. Joseph Health, Covenant Health in West Texas, Facey Medical Foundation in Los Angeles, Hoag Memorial Presbyterian in Orange County, California, Kadlec in Southeast Washington, Pacific Medical Centers in Seattle, and Swedish Health Services in Seattle.

Bringing these organizations together is a reflection of each of our unique missions, increasing access to health care and bringing quality, compassionate care to those we serve, with a focus on those most in need. By coming together, Providence St. Joseph Health has the potential to seek greater affordability, achieve outstanding and reliable clinical care, improve the patient experience and introduce new services where they are needed most.

It begins with heritage

The founders of both organizations were courageous women ahead of their time. The Sisters of Providence and the Sisters of St. Joseph of Orange brought health care and other social services to the American West. Now, as we face a different landscape – a changing health care environment – we draw on their spirit of faith, flexibility and fortitude to guide us through these transformative times.

Providence Health & Services

In 1856, Mother Joseph and four Sisters of Providence established hospitals, schools and orphanages across the Northwest. Over the years, other Catholic sisters transferred sponsorship of their ministries to Providence, including the Little Company of Mary, Dominicans and Charity of Leavenworth. Recently, Swedish Health Services, Kadlec Regional Medical Center and Pacific Medical Centers have joined Providence as secular partners with a common commitment to serving all members of the community. Today, Providence serves Alaska, California, Montana, Oregon and Washington.

St. Joseph Health

In 1912, a small group of Sisters of St. Joseph landed on the rugged shores of Eureka, California, to provide education and health care. The ministry later established roots in Orange, California, and expanded to serve Southern California, the California High Desert, Northern California and Texas. The health system established many key partnerships, including a merger between Lubbock Methodist Hospital System and St. Mary Hospital to form Covenant Health in Lubbock Texas. Recently, an affiliation was established with Hoag Health to increase access to services in Orange County, California.

MISSION, VISION, AND VALUES

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision

Health for a Better World

Our Values

Compassion

Dignity

Justice

Excellence

Integrity

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

As a ministry founded by the Sisters of St. Joseph of Orange, Santa Rosa Memorial Hospital, a member of Providence St. Joseph Health, lives out the tradition and vision of community engagement set out hundreds of years ago. Providence St. Joseph Health is a new organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Together, our 111,000 caregivers (all employees) serve in 50 hospitals, 829 clinics and a comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. The Providence St. Joseph Health family includes: Providence Health & Services, St. Joseph Health, Covenant Health in West Texas, Facey Medical Foundation in Los Angeles, Hoag Memorial Presbyterian in Orange County, California, Kadlec in Southeast Washington, Pacific Medical Centers in Seattle, and Swedish Health Services in Seattle.

Bringing these organizations together is a reflection of each of our unique missions, increasing access to health care and bringing quality, compassionate care to those we serve, with a focus on those most in need. By coming together, Providence St. Joseph Health has the potential to seek greater affordability, achieve outstanding and reliable clinical care, improve the patient experience and introduce new services where they are needed most.

SRMH is an acute-care hospital founded in 1950 by the Sisters of St. Joseph of Orange. Located in Santa Rosa, California, the facility has 338 licensed beds with additional off-site facilities throughout the county. Santa Rosa Memorial Hospital has a staff of more than 2,000 caregivers and professional relationships with more than 430 local physicians. As the designated Level II

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Regional Trauma Center for Sonoma, Mendocino, Napa and Lake Counties, Santa Rosa Memorial Hospital provides a wide range of specialty services including critical care, cardiovascular care, stroke care, women's and children's services, cancer care and orthopedics. The hospital is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

Outside the hospital walls, SRMH has established itself as an anchor institution in leading multiple and various community health improvement programs, initiatives, and partnerships aimed at increasing access to care and improving the health and quality of life of the communities we serve. Prominent among these efforts are the provision of free medical care for all who seek it at our Mobile Health Clinic, and the provision of free dental care to children at our St. Joseph Health Community Dental Clinic.

COMMUNITY BENEFIT INVESTMENT

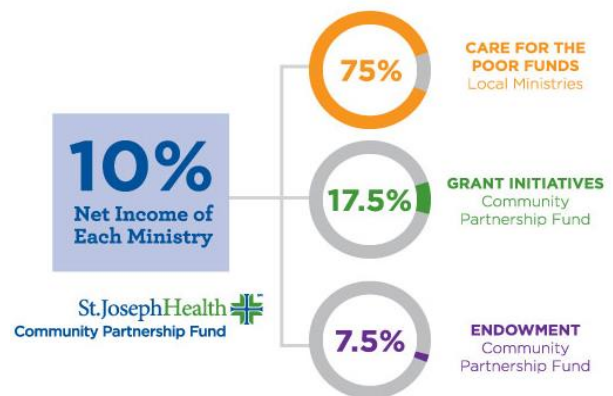
St. Joseph Health, Santa Rosa Memorial Hospital invested \$48,718,594 in community benefit in Fiscal Year 2018, ending June 30, 2018 (FY18). In FY18, Medicaid shortfall was \$26,617,577, however, when hospital fee was accounted for it was \$34,914,247.

ORGANIZATIONAL COMMITMENT

SRMH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved.

In 1986, St. Joseph Health created the St. Joseph Health Community Partnership Fund (SJH CPF) (formerly known as the St. Joseph Health System Foundation) to improve the lives of low-income individuals residing in local communities served by SJH Hospitals.

Each year, SRMH allocates 10 percent of its net income (net realized gains and losses) to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospital Care For The Poor programs. 17.5 percent is used to support SJH Community Partnership Fund grant initiatives. The remaining 7.5 percent is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.



Furthermore, SRMH will endorse local nonprofit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local nonprofit organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas.

Community Benefit Governance and Management Structure

SRMH further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and the Community Partnership Manager are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on CB programs and activities, including opportunities for community participation.

A charter approved in 2007 establishes the formation of the St. Joseph Health Sonoma Community Benefit Committee (CBC). The role of the CBC is to support the Boards of Trustees of both SRMH and PVH in overseeing community benefit issues. The CBC is charged with recommending policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and approving the annual Care For The Poor budget.

The CBC has a minimum of eight members including at least three members of the Boards of Trustees. Current membership includes 5 members of the SRMH Board of Trustees, 3 members of the PVH Board of Trustees, and 7 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The CBC generally meets every other month.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for CB performance.

Community Benefit Committee (CBC)

- CBC serves as an extension of the Boards of Trustees to provide direct oversight for all charitable program activities and ensure program alignment with *Advancing the State of the Art of Community Benefit* (ASACB) Five Core Principles (Emphasis on Communities with Disproportionate Unmet Health Needs, Emphasis on Primary Prevention, Build a

Seamless Continuum of Care, Community Capacity Building, and Collaborative Governance). It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.

- The CBC provides recommendations to the Boards of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate emergency department utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community Representatives on the CBC

- Promote and take necessary actions to support the achievement of committee goals as specified in the Community Benefit Implementation Strategy Plan and in response to the CHNA;
- Ensure accountability to the CBC's ongoing plans and strategic initiatives;
- Act as ambassadors for the CB Department and help to establish strategic community partnerships;
- Engage diverse stakeholders in CB planning and implementation to assist SJH in achieving its mission in serving those vulnerable populations outlined in the CBIP;
- Recommend to SJH management ongoing opportunities for education, information sharing, and collaboration with outside agencies, individuals, and community workgroups in order to achieve desired goals and outcomes.

The CBC, CEO, and Executive Management Team were involved in the CHNA prioritization process as well as throughout the CB planning process as key informants, advisors, subject matter experts, and ultimately as decision-makers and approvers of the CB plan. This process was informed and shaped by our ministry's Mission Outcomes of Sacred Encounters, Healthiest Communities, and Perfect Care; in fact, this CB Implementation Strategy Plan is one of the primary ways in which achieve these outcomes, particularly in making the community we serve among the healthiest communities in the state.

This CB plan is also aligned with our ministry's overall strategic plan and its goals:

- Be the preferred health partner for those we serve.
- Transform care and improve population health outcomes, especially for the poor and vulnerable.

- Lead the way in improving our nation's mental well-being.
- Extend our commitment to whole person care for people at every age and stage of life.
- Simplify and improve access, including moving clinically appropriate services to digital experiences.
- Engage with partners in addressing the social determinants of health, including education and housing.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Patient Financial Assistance Program

The St. Joseph Health (SJH) Financial Assistance Program helps to make our health care services available to everyone in our community needing emergent or medically necessary care. This includes people who do not have health insurance and are unable to pay their hospital bill, as well as patients who do have insurance but are unable to pay the portion of their bill that insurance does not cover. In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment. At St. Joseph Health, Santa Rosa Memorial Hospital, our commitment is to provide quality care to all our patients, regardless of their ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance or are worried about their ability to pay for their care. This is why we have a Financial Assistance Program for eligible patients. In FY18, SRMH provided \$5,352,280 in free and discounted care following a policy providing assistance to patients earning up to 500% of the federal poverty level. This resulted in 5,330 patients receiving free or discounted care.

For information on our Financial Assistance Program click or visit this link:

https://www.stjoesonoma.org/documents/Patient-Financial-Assistance/Sonoma_FABrochure_2016.pdf

Medi-Cal (Medicaid)

St. Joseph Health, Santa Rosa Memorial Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY18, SRMH provided \$26,617,577 in Medicaid shortfall, excluding the hospital fee of \$8,296,670.

COMMUNITY

Definition of Community Served

SRMH provides southern Mendocino, northern Marin, and Sonoma Counties' communities with access to advanced care and advanced caring. The hospital's service area extends from Ukiah in the north, Marshall in the south, Sonoma Valley in the east and Bodega Bay in the west. Our Hospital Total Service Area includes the cities of Santa Rosa, Petaluma, Sebastopol, Windsor, Healdsburg, Rohnert Park, Cotati, Sonoma, Cloverdale, Ukiah, and Point Arena.

Community Profile

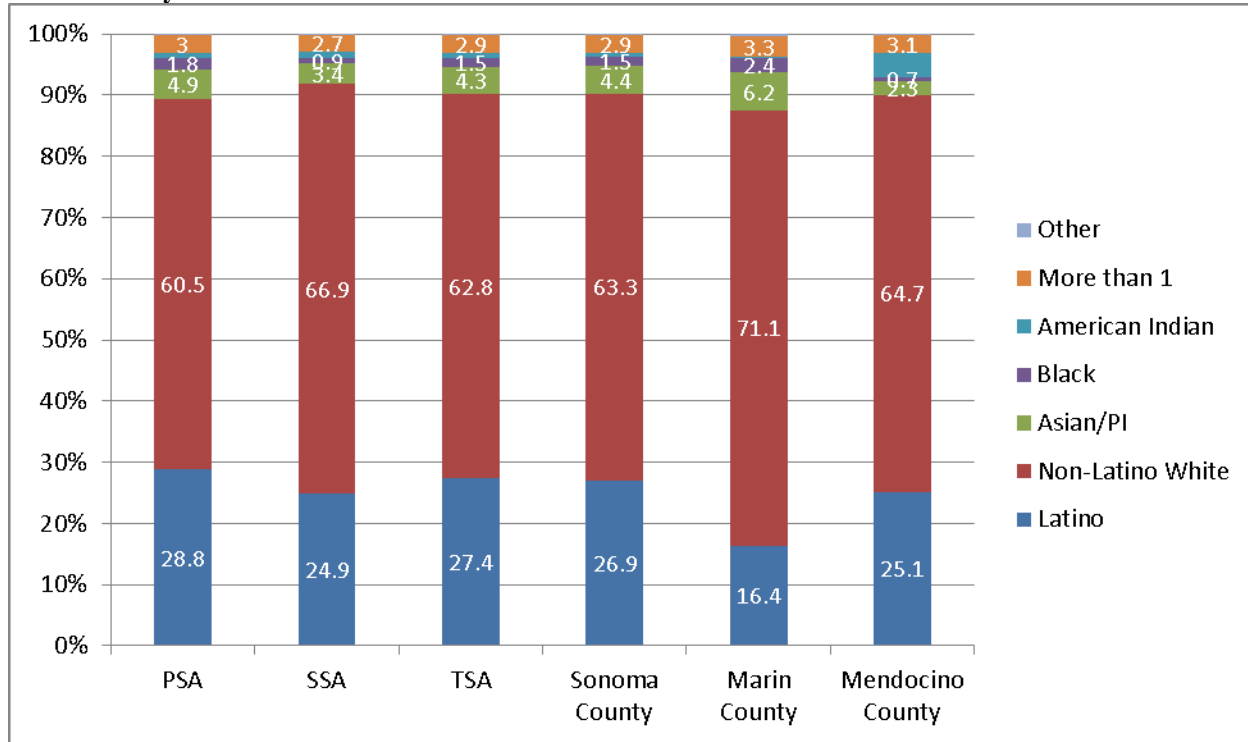
The table and graph below provide basic demographic and socioeconomic information about the SRMH Service Area and how it compares to Sonoma, Marin, and Mendocino Counties and the state of California. The Total Service Area (TSA) of Santa Rosa Memorial Hospital includes approximately 537,000 people. Over 90% of the population of the Service Area is in Sonoma County, and over 99% of Sonoma County's population is within the Service Area. About 38,000 people in the Secondary Service Area live in Mendocino County; this represents approximately 42% of the Mendocino County population. Less than 1% of the service area is in Marin County, but Marin's data is presented for completeness. Comparisons to Marin County are not discussed in this report.

Compared to the state, the Service Area (and Sonoma and Mendocino Counties) has higher percentages of elderly and non-Latino Whites. Median income of the TSA is very similar to California but there is less reported poverty. Note that Mendocino County (and the portions of it within the Service Area) has higher rates of households and children in poverty than both Sonoma and California.

Service Area Demographic Overview

Indicator	PSA	SSA	TSA	Sonoma County	Marin County	Mendocino County	California
Total Population	341,323	196,056	537,379	503,284	259,572	89,313	38,986,171
Under Age 18	21.3%	20.0%	20.8%	20.6%	20.3%	20.9%	23.6%
Age 65+	15.9%	18.6%	16.9%	16.9%	20.0%	19.1%	13.2%
Speak only English at home	73.3%	75.7%	74.2%	74.3%	76.5%	78.6%	56.2%
Do not speak English "very well"	11.3%	10.5%	11.0%	10.9%	9.1%	9.8%	19.1%
Median Household Income	\$62,497	\$61,955	\$62,290	\$63,910	\$95,860	\$44,881	\$62,554
Households below 100% of FPL	7.8%	8.5%	8.0%	7.6%	5.3%	14.1%	12.3%
Households below 200% FPL	22.7%	22.2%	22.5%	21.6%	13.6%	35.3%	29.8%
Children living below 100% FPL	15.1%	17.9%	16.1%	15.1%	10.8%	28.4%	22.7%
Older adults living below 100% FPL	6.6%	7.0%	6.8%	6.8%	5.3%	8.9%	10.2%

Race/Ethnicity



Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The PSA is comprised of Santa Rosa, Sebastopol, Windsor, Healdsburg, Rohnert Park, Fulton, and Graton. The SSA is comprised of Petaluma, Cotati, Sonoma, Cloverdale, Guerneville, Forestville, Gualala, Penngrove, Kenwood, Glen Ellen, Geyserville, Monte Rio, Bodega Bay, Bodega, Cazadero, The Sea Ranch, Stewarts Point, Occidental, Hopland, Annapolis, Jenner, Ukiah, and Point Arena.

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Table 1. Cities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Santa Rosa	95401,95402,95403, 95404,95405,95406, 95407, 95409	PSA
Rohnert Park	94928	PSA
Rohnert Park	94927	PSA
Windsor	95492	PSA
Sebastopol	95472	PSA
Sebastopol	95473	PSA
Healdsburg	95448	PSA
Fulton	95439	PSA
Graton	95444	PSA
Petaluma	94954	SSA
Petaluma	94952	SSA
Petaluma	94975	SSA
Petaluma	94953	SSA
Petaluma	94955	SSA
Sonoma	95476	SSA
Cloverdale	95425	SSA
Ukiah	95482	SSA
Cotati	94931	SSA
Forestville	95436	SSA
Guerneville	95446	SSA
Gualala	95445	SSA
Penngrove	94951	SSA
Kenwood	95452	SSA
Glen Ellen	95442	SSA
Geyserville	95441	SSA
Point Arena	95468	SSA
Monte Rio	95462	SSA
Bodega Bay	94923	SSA
Cazadero	95421	SSA
The Sea Ranch	95497	SSA
Stewarts Point	95480	SSA
Bodega	94922	SSA
Occidental	95465	SSA
Hopland	95449	SSA
Annapolis	95412	SSA
Jenner	95450	SSA

Figure 1 (below) depicts the Hospital's PSA and SSA. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 1. Santa Rosa Memorial Hospital Total Service Area



Community Need Index (Zip Code Level) Based on National Need

The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. The Community Need Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

- Income Barriers (Elder poverty, child poverty and single parent poverty);
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);

- Housing Barriers (Housing, renting percentage).

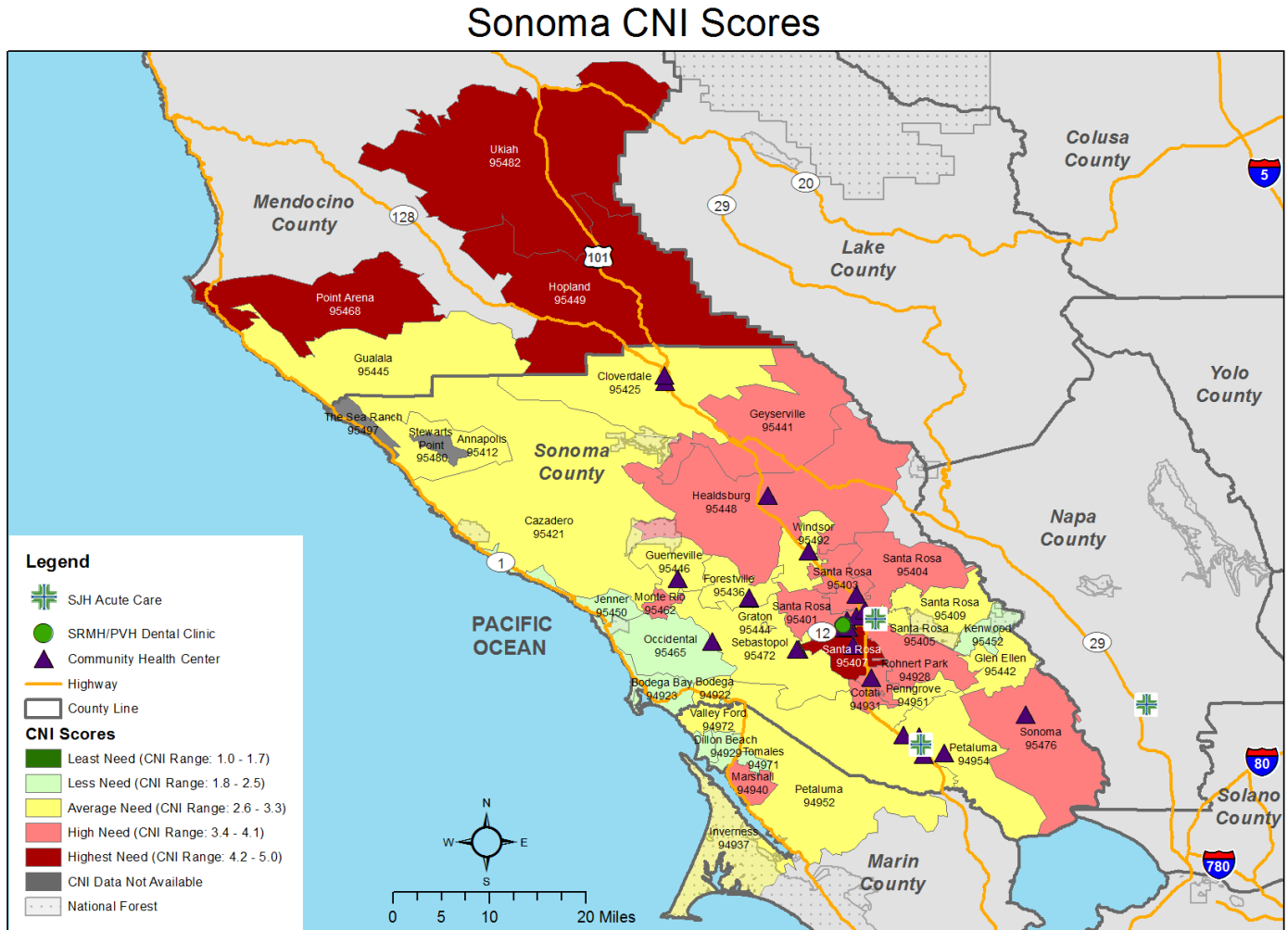
This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.) The CNI is used to draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, the ZIP code 95407 on the CNI map is scored 4.2-5.0, making it a Highest Need community.

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Figure 2 (below) depicts the Community Need Index for the *hospital's geographic service area based on national need*. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

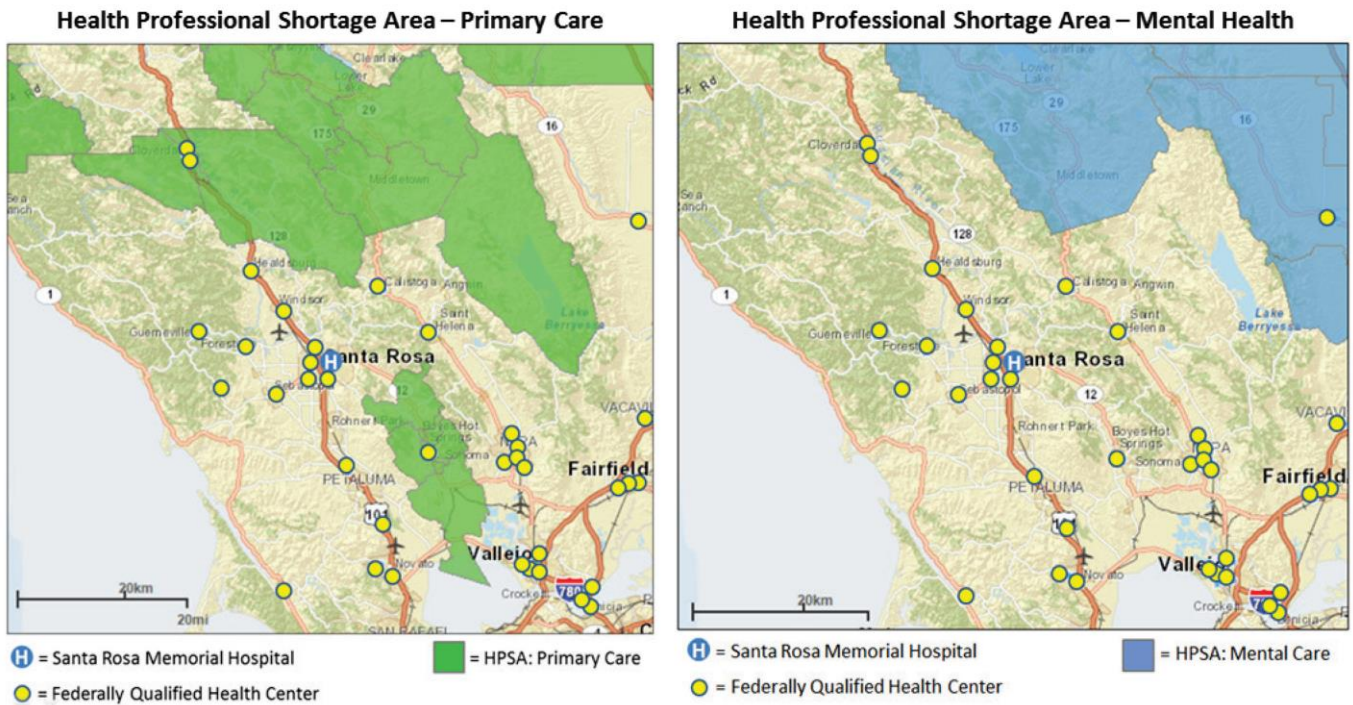
Figure 2. Santa Rosa Memorial Hospital Community Need Index (Zip Code Level)



Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although SRMH is not located in a shortage area parts of the hospital's service area to the north and east are shortage designated, indicating a need for additional primary care physicians. The map below depicts these shortage areas relative to SRMH's location.

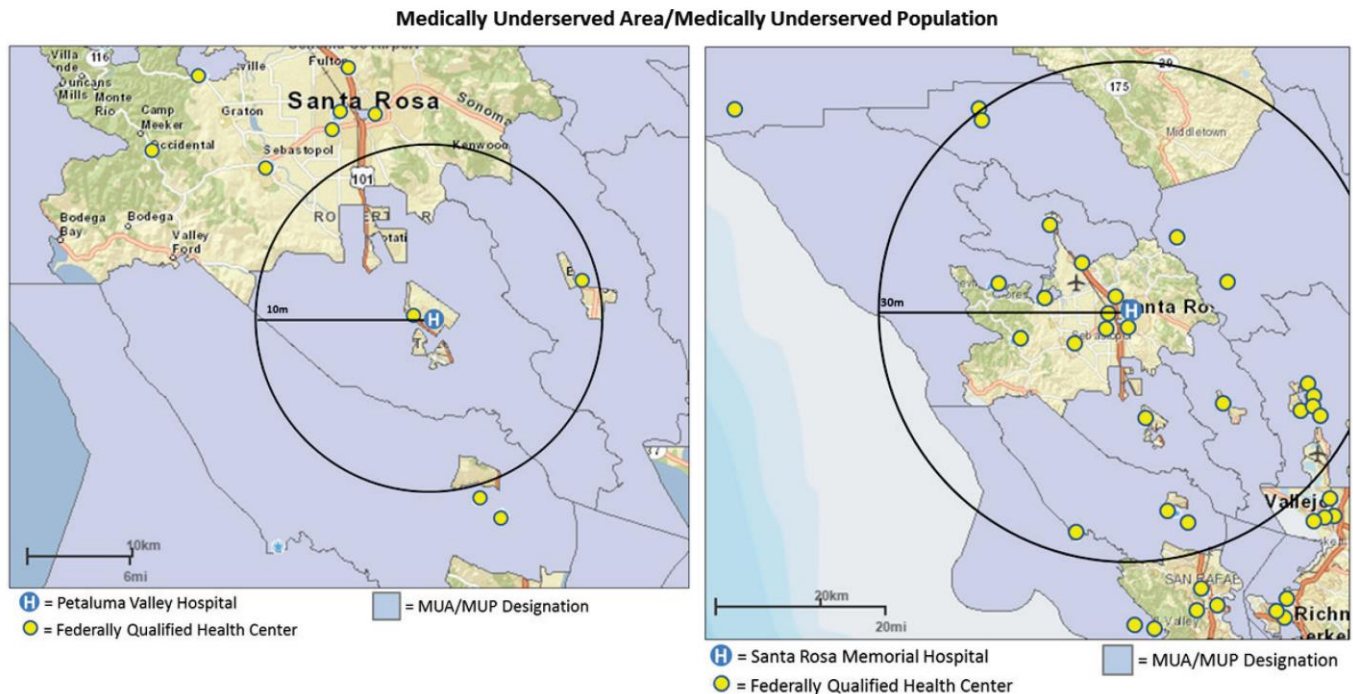
Figure 3. Santa Rosa Memorial Hospital Health Professions Shortage Area



Medical Underserved Area/Medical Professional Shortage Area

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary. The map below depicts the Medically Underserved Areas/Medically Underserved within a 30 mile radius from SRMH.

Figure 4. Santa Rosa Memorial Hospital Medically Underserved Areas/Medically Underserved Population Area



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs, Assets, Assessment Process and Results

The Community Health Needs Assessment (CHNA) process was guided by the fundamental understanding that much of a person and community's health is determined by the conditions in which they live, work, play, and pray. In gathering information on the communities served, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. When data was publicly available, it was collected at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.

Examples of the types of information that was gathered, by health factor, are:

Socioeconomic Factors – income, poverty, education, and food insecurity

Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden

Health Behaviors – obesity, sugary drink consumption, physical exercise, smoking, and substance abuse

Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker

In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, by zip code whenever possible. The health conditions that were examined included:

Health Outcomes – overall health condition, asthma, diabetes, heart disease, cancer, and mental health

Secondary Data/Publicly available data

Within the guiding health framework for the CHNA, publicly available data was sought that would provide information about the communities (at the city and zip code level when available) and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey Neighborhood Edition). In total, 81 indicators were selected to describe the health needs in the hospital's service area.

Collaborative Partners

Many local government agencies and not-for-profit organizations collaborated with St. Joseph Health in the CHNA process. Among these are the following:

- Sonoma County Department of Health Services, i.e., County Public Health
- Community Child Care Council (4Cs) of Sonoma County
- First 5 Sonoma County
- Burbank Housing
- Community Foundation Sonoma County
- Sonoma County Sheriff's Office
- City of Santa Rosa Violence Prevention Partnership
- Community Action Partnership of Sonoma

- Sonoma County ACEs Connection
- Sonoma County Economic Development Board
- Sonoma County Permit & Resource Management Department
- Sonoma County Environmental Health & Safety
- Buckelew Programs
- Sonoma County Office of Education
- Sonoma County Community Development Commission
- La Luz Community Center
- Petaluma People Services Center
- Sutter Health
- Kaiser Permanente
- Santa Rosa Community Health Centers
- West County Health Centers
- Petaluma Health Care District
- Petaluma Health Center
- Alliance Medical Center
- Sonoma West Medical Center
- Palm Drive Health Care District
- North Sonoma County Health Care District
- Sonoma Valley Health Care District
- Russian River Area Resources and Advocates
- Community Health Initiative of the Petaluma Area
- Latino Service Providers
- Sonoma County Human Services Department
- Sonoma County Task Force on the Homeless
- Sonoma County Health Care for the Homeless Coalition
- Mendocino County Department of Health & Human Services
- Healthy Mendocino

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by SRMH. In addition, the findings from the recent Community Building Initiative in Roseland were considered as an additional source.

The following concerns were identified as important by participants in the community resident and nonprofit/government stakeholder focus groups and the community forum:

Mental Health	Substance Abuse	Housing
Economic Insecurity	Access to Resources	Immigration Status
Oral Health	Obesity	Diabetes
Crime and Safety	Insurance and Cost of Care	Food and Nutrition
Transportation	Homelessness	Early Childhood Development
Health Conditions (heart disease, asthma, cancer)		

Upon completion of the community input process, a selection and prioritization process (described below) resulted in the selection of the following three priority needs for the SRMH CHNA and CB plan:

Behavioral Health (Mental Health & Substance Abuse)
Homelessness & Housing Concerns
Access to Resources

For a more detailed description of the CHNA process and data collected, please refer to the SRMH FY17 CHNA Report on the St. Joseph Health website at this location:

https://www.stjoesonoma.org/documents/Community-Benefit/FY17_CHNA_REPORT_SRM_FINAL.pdf

Identification and Selection of Significant Health Needs

The compiled quantitative community level data and community input (focus group and community forum data) were analyzed to generate a list of significant health needs. The matrix below shows the 17 health needs identified through the selection and initial prioritization processes. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

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Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Groups (FG)	N.P./ Govt. Stakeholder FG	Community Forum
Mental Health	Health Outcome	47.8	✓	✓	✓	✓
Substance Abuse	Health Behavior	44.7	✓	✓	✓	✓
Obesity	Health Behavior	44.2	✓	✓	✓	
Heart Disease	Health Outcome	44.0	✓	✓		
Oral Health	Clinical Care	43.8		✓	✓	
Access to Resources	Clinical Care	42.3		✓	✓	
Housing Concerns	Physical Environment	41.7	✓	✓	✓	✓
Diabetes	Health Outcome	41.2	✓	✓	✓	
Food and Nutrition	Health Behavior	40.7	✓	✓		✓
Early Childhood Development	Clinical Care	39.0			✓	✓
Insurance and Cost of Care	Clinical Care	36.7	✓	✓		
Homelessness	Socioeconomic	36.2	✓		✓	✓
Economic Insecurity	Socioeconomic	35.0	✓	✓	✓	✓
Asthma	Health Outcome	33.7	✓	✓		
Cancer	Health Outcome	33.5	✓	✓		
Crime and Safety	Physical Environment	33.2	✓	✓	✓	
Immigration Status	Socioeconomic	31.0	✓	✓	✓	✓

Prioritization Process and Criteria

To rank order the list of significant health needs and ultimately select the three health needs to be addressed by SRMH, a four-step process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry.

Step 1: Using criteria that were developed in collaboration with the St. Joseph Health Community Partnership Department and the SRMH Community Partnership Manager, each health need was scored on several criteria (seriousness of the problem, scope of the problem, health disparities, importance to the community, potential to affect multiple health issues, implications for not proceeding).

Step 2: A working group of internal stakeholders that included the SRMH CEO, Vice President of Mission Integration, , Community Partnership Manager, and Population Health Medical Director was convened and applied four additional criteria to each need:

- **Sustainability of Impact:** The degree to which the ministry's involvement over the next 3 years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.

- **Opportunities for Coordination and Partnership:** The likelihood that the ministry could be part of collaborative efforts to address the problem.
- **Focus on Prevention:** The existence of effective and feasible prevention strategies to address the issue.
- **Existing Efforts on the Problem:** The ability of the ministry to enhance existing efforts in the community.

Community Benefit Staff participating in the working group also considered a fifth criterion:

- **Organizational Competencies:** The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

Step 3: Two final criteria were considered by the Community Partnership Manager for each health need.

- **Relevance to the Mission of St. Joseph Health:** Is this area relevant to or aligned with the Mission of St. Joseph Health?
- **Adherence to Ethical and Religious Directives:** Does this area adhere to the Catholic Ethical and Religious Directives?

If the answer was “No” to either question, the health need was dropped from further consideration. None of the needs were dropped at this step.

Step 4: The final step of prioritization and selection was conducted by the SRMH Community Benefit Committee, which reviewed the list of identified health needs rank-ordered by the results of the first three steps of the prioritization process. The Committee discussed each need and its relevance to the ministry, the potential for progress on the issue, and the potential role of the ministry in addressing the need. After extensive discussion, the Committee selected three priorities for inclusion in the plan.

Community Health Needs Prioritized

- **Access to Resources:** Ensuring access to affordable, quality health care services is important to protecting both individual and population health, eliminating health disparities and promoting overall quality of life in the community. This includes most barriers to accessing health care services and other necessary resources, such as income, lack of adequate insurance, immigration status, transportation, a shortage of providers and specialists, language barriers, and resources being unavailable outside of working hours.

The CBC noted that while many adults in Sonoma County are able to obtain insurance coverage and access regular healthcare in the wake of the implementation of the Affordable Care Act (ACA), disparities persist. Specifically, lower income residents have difficulty accessing care, as many remain uninsured due to high premium costs and those with public insurance face barriers to finding providers who accept MediCal.

Foreign-born residents who are not U.S. citizens also face stark barriers in obtaining insurance coverage and accessing care. Among those who do have insurance coverage, primary data identified other barriers to accessing care including that there are not enough primary healthcare providers in Sonoma County to meet the high demand. The CBC recognizes this as an ongoing, high-priority need, and one which, given the existing SRMH Community Benefit programs (mobile health and dental clinics, fixed-site dental clinic, and in-home care), we are uniquely qualified with appropriate capacity to address.

- **Homelessness and Housing Concerns:** These two needs were combined by the CBC in recognition of the fact that the two issues, while identified separately in the data collection process, are inextricably linked and cannot be effectively addressed separately, and that while homelessness is the more visible problem, the stress of housing insecurity and the threat of homelessness are equally injurious to community and individual health. Housing is considered a primary social determinant of health, and the lack of housing or affordable housing contributes to and exacerbates multiple adverse health conditions.

Stakeholders noted that 2,835 homeless persons were found during the January 26, 2017 Sonoma County Homeless Count. While this number reflects a declining trend in homelessness in Sonoma County over the past five years, the number is still very large: on any given night, 5.6 people out of every 1,000 residents are homeless, and many of them in much more visible locations than in previous years' counts. The CBC believes it is imperative that we join in our community's efforts to combat these trends as we see this as the most prominent social determinant of health that we must address. Our primary focus will be on the condition of homelessness, including the development of permanent supportive housing, providing health care to homeless individuals, prevention of homelessness, and mitigating its impact on communities. We also intend to partner with other community organizations to address issues of housing affordability, availability, overcrowding, and quality.

- **Behavioral Health:** Mental Health and Substance Use were combined by the CBC in recognition of the fact that mental health and substance use disorders often go hand-in-hand and for many patients are co-occurring conditions. We prefer the term Behavioral Health to refer to these conditions collectively. In addition, the CBC noted that at the conclusion of Step 3 of the prioritization process, these were the first and second highest ranked concerns. Both concerns were raised throughout the community input process and received a high number of votes at the community forum.

Although the data shows a better ratio of population to mental health providers in Sonoma and Mendocino Counties than the state, focus group participants spoke of shortages of providers and services for mental health and substance abuse. In Sonoma

County, for instance, many low-income individuals with mental health concerns do not have access to the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly funded treatment services are significant barriers for many. Furthermore, limited integration of mental health services within the health care system also leads to missing opportunities for early problem identification and prevention. Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health. As a result, the CBC felt that the focus on mental health and substance abuse, i.e., behavioral health, with a particular focus on trauma-informed community-based prevention and resilience in the face of adverse community experiences, was of paramount importance to our ministry and our community.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We recognize that in choosing to focus on the needs we have prioritized, we will not be addressing directly other needs that are also important in our community. For instance, we recognize that cardiovascular disease is the leading cause of death in our community, and that heart disease, obesity, and diabetes were all among the highest priority community health needs identified in our CHNA process. In not selecting any of these chronic conditions as one of our community benefit priority focus areas, we are aware that other ongoing programs in our ministry and in our community are fully engaged in addressing them. We are committed to continue our involvement with community initiatives such as Hearts of Sonoma and the California Accountable Communities for Health Initiative, financial support for nonprofit organizations such as the Northern California Center for Well Being, and the HeartWorks cardiac rehab program.

With respect to some of the other needs identified in the CHNA process that were not prioritized for action through this plan, we intend to remain engaged in addressing oral health needs through our ongoing St. Joseph Health Community Dental Clinic and Mobile Dental Clinic; crime and safety through our continued involvement on the Santa Rosa Violence Prevention Partnership; and insurance and cost of care through our continued involvement on the Covered Sonoma and Sonoma Health Action Community Health Improvement committees. We also intend to incorporate other issues such as early childhood development in our behavioral health strategy as it is such a fundamental determinant of mental health later in life; and economic insecurity in our housing concerns strategy as it is a necessary ingredient in housing affordability. Similarly, with respect to immigration, we lack appropriate expertise or competency to offer a program, but we intend to develop a Medical Legal Partnership with a

local Legal Aid organization that will assist residents and patients with immigration issues, among others. And while food and nutrition is not to be directly addressed by our own programming, we anticipate that our ongoing support of local initiatives and organizations involved in cardiovascular disease prevention will include a consideration and inclusion of strategies to address this need.

Furthermore, we will continue funding other local nonprofit organizations through grants from our Care for the Poor program managed by the SRMH Community Benefit Department, and we will encourage and endorse local nonprofit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout the SRMH service areas.

COMMUNITY BENEFIT PLAN

SRMH anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the SRMH CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by SRMH in the CB Plan/Implementation Strategy.

Summary of Community Benefit Planning Process

The process used to select the priority community health needs to be addressed by both this SRMH Community Benefit Implementation Strategy as well as the Petaluma Valley Hospital (PVH) Community Benefit Implementation Strategy is described above on pages 20-27. Upon adoption of the CHNA by the SRMH/PVH Community Benefit Committee on June 27, 2017, the Community Benefit Department staff began the process of developing this plan in response to the priority needs identified in the CHNA. These processes were undertaken for the entirety of the combined service areas of SRMH and PVH as St. Joseph Health Sonoma considers these strategies to be interconnected and together are in service to the needs of the entire county and community. This began with the retention of an external consultant to conduct a more detailed study of the behavioral health needs throughout the county. Utilizing this data, the CBC was again tapped in its advisory role to provide its knowledge of the community in developing this strategy. At the regular meeting of the CBC on August 22, 2017, and again in a smaller subcommittee, the CB staff presented its recommended initial draft of a strategy plan. Incorporating CBC input in subsequent drafts of the plan, staff reviewed the plan and sought input from the SRMH/PVH Population Health Department and the Executive Management Team, as well as from the St. Joseph Health system office staff of the Community Partnership Fund and with staff from the Prevention Institute. This process yielded this final draft plan that was submitted to and approved by the CBC at their meeting on October 24, 2017.

Addressing the Needs of the Community:

FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan for the combined service areas of SRMH and PVH FY18 Accomplishments

1. Initiative/Community Need being Addressed: Access to Resources

Goal (anticipated impact): Improve health in the communities served by SRMH by increasing low-income and vulnerable populations' access to health care and resources needed to maintain health through direct provision of free or low-cost clinical services and by addressing the community determinants of health experienced by this population with case management services and additional resource assistance.

Outcome Measure	Baseline	FY18 Target	FY18 Results
Numbers of low-income patients who are provided free and low-cost direct health care services throughout the SRMH & PVH service areas.	10,850 patients served; 24,200 encounters	14,765 patients served; 30,200 encounters	16,502 patients served; 34,935 encounters

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY18 Results
1. Establish new CARE Network program	Number of patients served; number of encounters	0 (new program in 2018)	3,500 patients served; 4,000 encounters*	4,137 patients served; 4,759 encounters*
2. SJH Dental programs	Number of patients served; number of encounters; percentage of patients case complete	9,200 patients served; 14,000 encounters; 66.2% case complete	9,500 patients served; 15,000 encounters; 67% case complete	9,881 patients served; 16,520 encounters; 71.4% case complete
3. House Calls program	Number of patients served; number of encounters	150 patients served; 7,000 encounters	165 patients served; 7,700 encounters	327 patients served; 6,026 encounters
4. Mobile Health Clinic	Number of patients served; number of encounters	1,500 patients served; 3,200 encounters	1,600 patients served; 3,500 encounters	2,157 patients served; 4,645 encounters

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		encounters		
5. Open Access	Number of patients linked to medical home for ongoing care by a primary care provider (PCP)	1,292 encounters (6 months of data)	2,500 encounters	2,985 encounters

** Reported results based on 6 month data (Jan-June).*

Key Community Partners: Santa Rosa Community Health, Petaluma-Rohnert Park Health Centers, West County Health Centers, Alliance Health Center, Catholic Charities, Community Action Partnership, County of Sonoma Department of Health Services, Petaluma People Services Agency, Redwood Community Health Coalition, Redwood Gospel Mission, Santa Rosa Resurrection Parish, First 5, Burbank Housing, Community Child Care Council of Sonoma County, Santa Rosa Junior College, North Bay Children’s Center, Santa Rosa City School District, Roseland Public School District, Sonoma Valley Unified School District, Shoreline Unified School District, Wilmar Union Elementary School District

FY18 Accomplishments:

- The Dental program began treating patients with silver diamine fluoride (SDF) in order to arrest/prevent caries reducing the number of patients referred out for hospital dentistry.
- The Dental program decreased wait time for treatment from 13 weeks in FY17 to 5 weeks in FY18.
- The Dental program’s Mighty Mouth school-based program provided screenings at 30 school sites, and returned to 14 of these to provide sealant treatments.
- The Dental program provided services to 206 emergency visit patients and increased the frequency of its “Special Needs Saturdays” open clinic hours from quarterly to monthly.
- The Mobile Health Clinic began providing outreach to homeless encampments, shelters, respite and permanent supportive housing units. Bringing services to where the homeless population can access them is building trust in that community, providing education on prevention, decreasing unnecessary ER visits and linking the population to necessary resources.
- The House Calls program provides home-based access to care and resources to mobility-limited patients thereby decreasing the need to be transported to our ER for care. This last year with the closing of one of our large internal medicine practices we were able to take on many high-need patients that couldn’t easily receive care in our medical group.

Addressing the Needs of the Community:

FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan for the combined service areas of SRMH and PVH

FY18 Accomplishments

2. Initiative/Community Need being Addressed: Behavioral Health

Goal (anticipated impact): Improve mental health, reduce substance use disorders, and advance health equity in the communities served by SRMH through a comprehensive set of approaches that include clinical services, coordination of community collaborative initiatives, and by strategically addressing the upstream community determinants of health (physical/built environment, social/cultural environment, and economic environment) that contribute to mental health and substance use disorders.

Outcome Measure	Baseline	FY18 Target	FY18 Results
The establishment and enhancement of key clinical and community-based programs to address critical, emergent, and upstream behavioral health needs and issues.	The baseline assumption is that insufficient programs existed in the community to meet the level of need.	As this is the first year of focus on this new priority, the target for FY18 is that the necessary groundwork will be laid for program development and that at least one new program will be established.	<ul style="list-style-type: none">• In partnership with the Redwood Community Health Coalition, designed and received funding for the Regional Behavioral Health Integration (RBHI) project.• In partnership with St. Joseph Health Medical Group, designed and funded a Community Psychiatric Resource Team.• Consolidated the Healthy for Life and Circle of Sisters programs and began the process of designing new behavioral health curricula for this school-based program to address restorative practice, resiliency and mindfulness to be implemented in the 2018-19 academic year.

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Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY18 Results
1. Convene and support a Sonoma County Behavioral Health Collaborative (BHC), a strategic local coalition of partners to coordinate services, to advocate for policy change, and to develop and launch community collaborative initiatives to address community determinants of behavioral health	Number of partners engaged in the BHC; number of meetings of the BHC	0; 0	10 partners engaged; 4 meetings held	A Behavioral Health Working Group of the Health Action Committee for Healthcare Improvement was formed and is being led by S JH. An initial meeting was held with eight participants. In addition, S JH is partnering with the Redwood Community Health Coalition in the RBHI project, focusing on behavioral health care transitions, expanding psychiatry workforce resources, and exploring options for increasing intensive outpatient behavioral health resources.*
2. Develop new and/or advance existing community initiatives focused on trauma-informed care and/or upstream community-based prevention strategies and interventions	Number of community initiatives developed and/or advanced	0	3	As part of the RBHI (above), a new Community Behavioral Health Programs Lead position was created in Community Benefit and has yet to be filled. A primary objective of this position is the development of these community initiatives, which will commence in the next reporting period.*
3. Evaluate the Circle of Sisters (COS) program to determine its effectiveness, to assess its ability to include ACEs and trauma-informed	Findings from formal program evaluation.	Program serves 175 student-participants	To be developed based on findings and conclusions from formal program evaluation.	The COS program was evaluated along with the Healthy for Life (H4L) program as part of the development of a

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elements in its curriculum, and to assess the necessity/desirability of continuing the program				school-based, youth focused behavioral health program. The conclusion was to discontinue the COS program as a stand-alone program and incorporate behavioral health components into the curricula offered in the schools through the H4L program. The development of these program aspects is underway. During FY18, COS served 193 individuals in 4,392 encounters, and H4L served 1,430 individuals in 28,133 encounters
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** Reported results based on 6 month data (Jan-June).*

Key Community Partners: ACEs Connection, Restorative Justice Collaborative, Restorative Resources, Sonoma County Human Services Dept., Sonoma County Dept. of Health Services, NAMI Sonoma, Buckelew Programs, CAP Sonoma, Sonoma County Office of Education, Petaluma Health Care District, Redwood Community Health Coalition and multiple FQHCs, Drug Abuse Alternative Center (DAAC), St. Joseph Health Medical Group, Petaluma Police Department, Committee on the Shelterless (COTS), Partnership Healthplan of California, Kaiser Permanente, multiple school districts.

FY18 Accomplishments: The original outcome measure for this priority community need was an improvement in a clinically based behavioral health metric. Given that this is the first year for engagement on this issue much groundwork would be needed to establish programs and services that would result in such an improvement, the outcome measure for this first year was changed to reflect that reality. As these programs and services take hold, a new outcome measure will be developed. Major accomplishments during this first year largely occurred only in the second six months of the year and were highlighted by the development of the RBHI referenced above. This collaboration with the local FQHC coalition was funded by the Providence St. Joseph Health Well-Being Trust and seeks to improve the community's behavioral health system of care through increased coordination in care transitions between and among County, clinic, and community-based providers, as well as the sharing of psychiatric resources, shared recruitment of additional psychiatric resources, and

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enhancement of primary care providers' capacities to address behavioral health issues in hospital, clinic, and community settings. The project also includes the creation of a broader community behavioral health coalition to examine community needs and resource gaps and to develop collaborative community-based responses to meet them. Among these will be the investigation of the expansion of intensive outpatient behavioral health services throughout the community.

In addition to the RBHI, a Community Psychiatric Resource Team project was created and funded in partnership with the St. Joseph Health Medical Group. Recruitment is currently underway for a psychiatrist and a team of psychiatric nurse practitioners to provide direct behavioral health services to Medi-Cal patients in hospital, community clinic, and private practice settings.

Another continuing project in FY18 which SJH Community Benefit funds and in which staff participate is the Petaluma Sober Circle, a serial inebriate program aimed at addressing the recovery needs of homeless individuals suffering from substance use disorders. This project is a collaboration among SJH, the Petaluma Health Care District, Petaluma Police Department, COTS, the Drug Abuse Alternative Center, Partnership Healthplan of California, Kaiser Permanente, Petaluma Health Center. The project features street outreach, inpatient recovery services, and outpatient case management to reduce the incidence of inappropriate emergency room admissions, incarceration, and public intoxication.

Addressing the Needs of the Community:

**FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan for the combined service areas of SRMH and PVH
FY18 Accomplishments**

3. Initiative/Community Need being Addressed: Homelessness & Housing Concerns

Goal (anticipated impact): Reduce the number of homeless individuals and increase the availability of health care services for those suffering from homelessness in the community.

Outcome Measure	Baseline	FY18 Target	FY18 Results
Increase in the amount and level of healthcare services being provided to homeless patients	The baseline assumption is that insufficient programs existed in the community to meet the level of need.	A more precise assessment of the level of need and the establishment of some level of new services.	An assessment of healthcare and supportive services in permanent supportive housing (PSH) units and sober living environments has been designed but not yet conducted. The SJH Mobile Health Clinic began a focus on homeless services at shelters and encampments. Funding for supportive services were provided to COTS, creating 11 new PSH units.*

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY18 Results
1.Mobile Health Clinic targeting homeless clients and shelters	Number of homeless patients served; number of encounters	0 (new focus of MHC program)	500 patients served; 1,500 encounters	176 Patients 574 Encounters*
2.Continue support of expansion of Project Nightingale (homeless medical respite Program)	Expanded number of beds for Project Nightingale patients	26 beds in two locations; 13 low acuity, 13 higher acuity	Expand number of higher acuity beds by 11 at new location in Palms Inn permanent supportive housing project	The feasibility of the expansion of Project Nightingale is underway. Obstacles identified include the capital investment necessary to undertake such expansion at the Palms Inn site. Alternatives being considered include expansion of Project Nightingale at Catholic Charities' Caritas Village project as well as the addition of homeless respite beds at COTS' Mary Isaak Center in Petaluma. Financial support for the existing Project

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				Nightingale continues uninterrupted.*
3. Promote development of permanent supportive housing (PSH) project(s)	Number of new PSH units/beds created	119 PSH units; 690 PSH beds	10% increase over baseline	11 new PSH units were funded by SJH at COTS' Mary Isaak Center. Through its involvement and leadership of the Continuum of Care Board, Community Benefit leadership has also played an active role in partnering with developers of PSH units, some of which may come online during this year while others will take longer to materialize.
4. Convene and support the Health Care for the Homeless Collaborative (HCHC)	Development of new HCHC implementation project	No current HCHC implementation project underway	One HCHC implementation project completed during the year	CB leadership has convened and led monthly meetings of the HCHC. An assessment project to evaluate the quantity and quality of healthcare and supportive services in PSH units and sober living environments (SLEs) has been designed and will launch in the next reporting year.*

** Reported results based on 6 month data (Jan-June).*

Key Community Partners: Continuum of Care, Sonoma County Community Development Commission, Catholic Charities, Santa Rosa Community Health, Petaluma-Rohnert Park Health Centers, West County Health Centers, West County Community Services, COTS, St. Vincent de Paul Society, Providence Supportive Housing, Burbank Housing, MidPen Housing, Partnership Healthplan of California, Sonoma County Sheriff's office, Santa Rosa and Petaluma Police Departments, Drug Abuse Alternative Center (DAAC)

FY18 Accomplishments: To directly improve the level of health care services delivered to homeless patients, the CB Mobile Health Clinic began visiting homeless shelters, encampments and the Project Nightingale clinic sites. The response and the utilization have been significant and there has been a reduction in ambulance calls and emergency room visits from these sites since the MHC began regular visits.

In an attempt to influence and improve the community's systemic response to the issue of homelessness and housing, the CB Community Partnership Manager has taken a proactive and leadership role in multiple coalitions and collaborative efforts: as the convening chair of the Health Care for the Homeless Collaborative, as the Chair of the Continuum of Care Board, and as the convener of the Sonoma Intersections Coalition, a new initiative funded by the SJH Community Partnership Fund to bring together a community coalition of organizations to work upstream on community determinants of health and health equity, in this case on the issue of housing equity.

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The creation of new PSH units was a goal that was felt very difficult to attain, but in partnership with a leading partner agency in COTS, SJH was able to leverage other funding from the Partnership Healthplan of California to pay for the capital improvements to a space at COTS' Mary Isaak Center (shelter) and the supportive services necessary to create 11 new PSH units.

Other Community Benefit Programs

Initiative/ Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)	FY18 Accomplishments
1. Community Building	NEIGHBORHOOD CARE STAFF (NCS)	The NCS program serves as the community outreach and engagement arm of the SRMH Community Benefit Department. NCS staff engage community resident leaders and agency partners to address local community health and quality of life issues, facilitate community conversations and planning, support collaborative initiatives, and drive policy and program development emerging from these efforts.	Broader Community	NCS focused on the ongoing support of the Roseland Community Council which it formed and is assisting in establishing it as an independent entity to sustain its community building efforts in the Roseland community. Furthermore, planning began in FY18 to shift focus to organizing community behavioral health programs staffed by the aforementioned Community Behavioral Health Programs Lead position. This will be a more focused form of community outreach and engagement than formerly conducted by NCS. In addition, SJH has launched the Sonoma Intersections Coalition with a focus on housing equity and community resident Engagement. This will be another form of focused

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				community engagement in lieu of the historic NCS engagements.
2. Healthy Eating, Active Living	PROMOTORES DE SALUD	The Promotores de Salud program bridges language and culture with the local Latino population, providing health information and referrals, conducting cooking, nutrition and "Your Heart Your Life" classes, and training community volunteer health promoters in heart health.	Broader Community	The Promotores de Salud program refined its focus during the reporting period to an increased emphasis on community health screenings and outreach. The Your Heart Your Life nutrition classes had seen diminishing attendance during the year and will be discontinued in the next reporting period. Participation rates in community health screenings have been significant, with 1,270 encounters and 988 patients served.
3. Healthy Eating, Active Living	HEALTHY FOR LIFE (H4L)	Healthy for Life is a school-based physical activity and nutrition program targeting schools in low-income neighborhoods. The program builds school capacity to support healthy eating and physical activity among its students.	SERVICES FOR THE POOR	H4L continues to offer nutrition and physical education in 18 schools throughout the county. As previously mentioned, behavioral health curriculum components are being added to the H4L program as a school-based, youth-focused behavioral health program is developed.

Evaluation Plan

The Community Benefit staff conducts annual surveys of program participants and compiles and reports on quantitative data related to program performance. These reports are published annually on the SJH Sonoma website.

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FY18 COMMUNITY BENEFIT INVESTMENT

In FY18 Santa Rosa Memorial Hospital invested a total of \$48,718,594 in key community benefit programs (excluding Medicare). In FY18, Medicaid shortfall was \$26,617,577, however, when hospital fee was accounted for it was \$34,914,247.

FY18 COMMUNITY BENEFIT INVESTMENT
SANTA ROSA MEMORIAL HOSPITAL
(Ending June 30, 2018)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ¹	Net Benefit
Medical Care Services for Vulnerable² Populations	Financial Assistance Program (FAP) (Traditional Charity Care-at cost)	\$5,352,280
	Unpaid cost of Medicaid ³	\$34,914,247
	Unpaid cost of other means-tested government programs	\$194,585
Other benefits for Vulnerable Populations	Community Benefit Operations	\$0
	Community Health Improvements Services	\$4,007,023
	Cash and in-kind contributions for community benefit	\$1,586,475
	Community Building	\$0
	Subsidized Health Services	\$1,571,460
	Total Community Benefit for the Vulnerable	\$47,626,070
Other benefits for the Broader Community	Community Benefit Operations	\$702,311
	Community Health Improvements Services	\$239,534
	Cash and in-kind contributions for community benefit	\$10,000
	Community Building	\$140,679
	Subsidized Health Services	\$0
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	\$0
	Total Community Benefit for the Broader Community	\$1,092,524
	TOTAL COMMUNITY BENEFIT (excluding Medicare)	\$48,718,594
Medical Care Services for the Broader Community	Unpaid cost to Medicare ⁴ (not included in CB total)	\$51,179,916

¹ Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

² CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid (referred to as Medi-Cal in California), Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

³ Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

⁴ Unpaid cost of Medicare is calculated using our cost accounting system. In IRS Form 990, Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial⁵ Summary of Accomplishments

The employees, volunteers and physicians of St. Joseph Health Sonoma are the greatest non-financial asset the organization provides for the community. Our team of caregivers is dedicated to providing the best patient-centered health care available in the region and volunteer in their own community on a regular basis.

In FY18, SJH caregivers participated in patient experience workshops and are continually looking for innovative ways to better serve and care for our patients. From quiet hours to friendly greetings, SJH employees, volunteers and physicians embrace our vision outcomes of perfect care, sacred encounters and healthy communities. Our caregivers spend countless hours volunteering in our community. From feeding the homeless with church and nonprofit groups, to staffing medical and health screening services at health fairs and other community events, our caregivers consistently give back. Caregivers volunteer time to serve on nonprofit community boards and they generously donate their hard-earned dollars towards efforts to assure needed services are available to the neediest members of our community and that we have a sound infrastructure of service organizations both now and in the future.

Community partnership is something we believe in and another non-financial benefit we provide the community. Community Benefit and other SJH leaders participate extensively in Sonoma County Health Action, our community's primary collective impact initiative that brings together government, business, nonprofit, education, and health care organizations in a multi-stakeholder coalition to address community determinants of health and health inequities. The SJH chief executive sits on the leadership council of Health Action and many other caregivers play prominent roles on many of its subcommittees and working groups.

While not a non-financial accomplishment, we also demonstrate our commitment to partnerships through our regular support of the community of nonprofit providers in the form of sponsorships of special events and targeted grants in support of critical services. In FY18, we provided such support to the following organizations:

10,000 Degrees	Community Foundation Sonoma County
Boys & Girls Club of Central Sonoma County	Council on Aging
Buckelew Programs	CTE Foundation
Catholic Charities	Daily Acts
Center for Well-Being	Economic Development Board
Child Parent Institute	Free to Be
Chop's Teen Club	Habitat for Humanity
Cloverdale Chamber of Commerce	Hispanic Chamber of Commerce
Committee on the Shelterless	La Luz
Community Action Partnership	LandPaths
Community Child Care Council (4Cs)	Latino Health Forum

⁵ Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.

*St. Joseph Health, Santa Rosa Memorial Hospital
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Latino Service Providers
LifeWorks
Living Room Center
Los Cien
Luther Burbank Center for the Arts
Mentor Me
NAMI
North Bay Organizing Project
PDI Surgery Center
Petaluma Healthcare District
Petaluma People Services Center
Red Cross
Redwood Empire Food Bank

Rotary Club of Santa Rosa Foundation
Santa Rosa Community Health
Santa Rosa Junior College Foundation
Santa Rosa Violence Prevention Partnership
Sonoma County Medical Association Alliance
Foundation
Senior Advocacy Services
TLC Child and Family Services
United Way Bay Area
Verity
Volunteer Center of Sonoma County
West County Health Center
YWCA

Finally, and most importantly, during the past year our community suffered one of the most devastating wildfires in California history. Thousands of homes were destroyed and many more thousands of lives were disrupted and lost. When other area hospitals were evacuated, their patients were brought to our hospitals and while dozens of our caregivers lost their homes in the fires, we remained open and many of these same caregivers worked around the clock to ensure that patients' needs were met and that our community could respond to the medical and health challenges brought on by the fires. This was perhaps our finest hour and a shining example of the non-financial contributions we make to the health of our community. It is this selflessness and philanthropic spirit that binds our community together and enables us to care for the Dear Neighbor without distinction, just as our founding Sisters have done since 1912.

Governance Approval

This FY18 Community Benefit Report was approved at the November 19, 2018 meeting of the Santa Rosa Memorial Hospital Community Benefit Committee of the Board of Trustees, as confirmed by the signature below of the Community Benefit Committee Chair.

Jeff Kolin, CBC Chair

Date